TENNCARE PROVIDER BILLING MANUAL FOR PROFESSIONAL MEDICARE CROSSOVER CLAIMS

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Document Information Page

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Amendment History

Summary of Change

Version #	Modified Date	Modified By	Section, Page(s) and Text Revised
0.1	03/06/2018	Toni Celestin	Original
0.2	01/30/2020	Mary Claire DuBois	Document checklist review performed
1.0	02/05/2020	Toni Celestin and Mary Claire DuBois	Final author review performed
1.1	02/26/2020	Toni Celestin	Updated Section 5
1.2	03/10/2020	Mary Claire DuBois	Expedited review performed
2.0	03/10/2020	Toni Celestin and Mary Claire DuBois	Final author review performed

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1 Introduction

1.1 Purpose

The Division of TennCare has developed a provider billing manual for Professional Medicare/Medicaid Crossover paper claims. This manual will contain all of the guidelines for submitting TennCare paper claims. Integrity, accuracy, completeness, and clarity are important details emphasized throughout this manual, as claims will not be suitable for processing if all required/situational information is not provided or legible.

This manual contains the following sections:

- Integrity of Claims
- Provider Registration
- Claim Submission
- Processing Claims
- Adjustment/Void Request
- Refunds
- Appeals

1.2 Contact Information

For information regarding member service eligibility, claim status, provider registration, mailing addresses, timely filing guidelines, and other information, providers may contact TennCare Provider Services at (800) 852-2683.

2 Integrity of Claims

A provider fraud task force was created to more effectively combat heath care fraud in the State of Tennessee. To find out more about this task force, please visit the Attorney General's website: http://www.tn.gov/attorneygeneral

Under the Tennessee False Claims Act (TFCA), those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of $5,500 to $25,000 per false claim. TennCare's policy related to fraud and the False Claims Act, PI 08-001.

See more at: https://www.tn.gov/tenncare/fraud-and-abuse.html

3 Provider Registration

TennCare recognizes the National Provider Identifier (NPI) as the only identifier to be submitted on claims in accordance with the Health Insurance Portability and Accountability Act (HIPAA) standards for claim transactions for healthcare services.

3.1 How is the NPI Obtained

Visit the National Plan & Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov

OR

By phone at (800) 465-3203

3.2 How is a Medicaid ID Obtained

Individual providers can submit key information to obtain a Medicaid ID for a new provider, whereas existing providers can enter key information which will allow us to receive updates electronically. No matter if you are a new provider to TennCare/Medicaid or an existing TennCare/Medicaid provider; you will need to register your information.

TennCare is now using web-based technology to simplify and improve the provider registration/re-verification process. Individual providers only need to register once to be added to the TennCare Council for Affordable Quality Healthcare (CAQH) roster. Once registered, all other updates should be maintained in CAQH. Single and multi-specialty groups will register and update their data and members from this web portal. All other provider entities will register electronically by clicking the All Other Provider Registration link below.

Once your registration is approved, you will receive a TennCare/Medicaid ID number. A valid TennCare/Medicaid ID number is required for participation in TennCare, Tennessee's Medicaid program. A valid TennCare/Medicaid ID number is required to:

1. Get prescriptions covered by the TennCare Pharmacy Benefit for TennCare members.
2. Submit Medicare/Medicaid "crossover" claims to TennCare for consideration of Medicare copays and deductibles for our members with Medicare as a primary carrier.
3. Contract with any TennCare Managed Care Organization (MCO) in order to provide medically necessary services to TennCare members.
4. Receive payments from TennCare's Electronic Health Record (EHR) Incentive Program.

Please select the appropriate link below to access provider registration information appropriate for your provider type.

Individual (Provider Person) Provider Registration Information

Examples of an individual provider:

- John Doe, M.D., a solo practitioner
- Jane Doe, M.D., a practitioner participating as a member of a group

All Other Provider Registration Information

Examples of a group provider:

- Any town Dental Practice (a group of General Dentists – Single Specialty)
- Happy Valley Medical Clinic (a group of Family Practitioners, Internists, and Pediatricians – Multi Specialty)
- ABC Medical Equipment (supplier of Durable Medical Equipment)
- Any city Hospital (Acute Care Hospital)
- Summertime County School District

Step by step instructions to electronic registration can be found by clicking:

https://www.tn.gov/content/dam/tn/tenncare/documents/GroupRegistrationInstructions.pdf link.

Per Federal Regulations, as defined in 42CFR 455.410(b), all providers reported on Medicaid/TennCare claims, whether the provider is a billing or secondary provider, must be registered as a TennCare provider. Please be advised that paper claims are rejected when the NPI is not registered with TennCare and will be returned to the billing provider as unprocessed.

Providers who are registered with TennCare but are not eligible for the entire claim dates of service will be denied payment for the claim that was submitted.

See more at: https://www.tn.gov/tenncare/providers/provider-registration.html

Did you know?

Any time that a provider updates their facility information via the Provider Database Management System (PDMS) portal, the new updated information needs to be reflected immediately on all claim submissions or resubmissions once verified.

4 Claim Submission

For Professional paper claims, the only acceptable claim forms are the official red drop-out ink form printed in Flint OCR Red (J6983 or exact match) ink. Compliance with this standard is required to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission, and image storing. It involves scanning a paper document to create a digital image of the text and then using software to store knowledge about that digital image. With OCR, it is very important that suppliers follow proper paper claim submission guidelines. The Division of TennCare returns claims that are not submitted on an original form.

All claim forms and Explanation of Benefits/Explanations of Medicare Benefits (EOB/EOMB) are required to be completed in a legible dark black ink; use 10- or 12-point font (COURIER NEW or TIMES NEW ROMAN) in ALL CAPS. Do not handwrite, circle, underline, or highlight any information on the claim or EOB/EOMB. All claim forms must have a complete EOB/EOMB attached and a Third-Party Liability (TPL) EOMB, when applicable.

4.1 Submissions of Taxonomy

When submitting a claim with a NPI number that is assigned to more than one service facility location, it is advised to submit these claims with the appropriate taxonomy number. Not doing so will result in delaying your claim to a final adjudication status. To alleviate this issue, TennCare has implemented that providers need to submit their taxonomy number, along with the "ZZ" qualifier, for the Billing Facility in Box 33A, while the Rendering Physician shall be reported in the shaded area of Box 24J (Qualifier to be reported in Box 24I) of the Health Care Finance and Administration (HCFA/CMS1500) claim form. Listed below are examples of taxonomy numbers:

- ANESTHESIOLOGY: 207L00000X
- EMERGENCY MEDICAL SERVICES: 207PE0004X
- MIDWIFE: 176B00000X
- NURSE'S AIDE: 376K00000X
- SLEEP SPECIALIST, PHD: 173F00000X

The reported taxonomy number must match with the NPI where the service was rendered or billed, when submitting claims to TennCare for adjudication.

Claim forms submitted without the required information will not be processed and will be Returned to the Provider (RTP) for the necessary corrections.

CMS-1500 forms submitted on paper must be mailed to its appropriate P.O. Box listed below:
Box 460 – CMS-1500 Claim Forms

Providers may refer to Appendix B, "CMS-1500 Claim Form," for form completion instructions and an example of the CMS-1500 claim form, along with an example of the RTP sheet.

Did you know?

- Sending claims to any other address not listed above does not guarantee a timely processing. They may be delayed, or even get lost in the USPS postal mail run.
- Certified mail does not guarantee that your claim will reach an adjudicated status. Claims are reviewed by receipt date order and submission guidelines.
- Certified/Registered mail is signed for by a DXC Technology representative. When signed, a confirmation is sent back to the provider. DXC keeps a confirmation tracking log by date of receipt to verify that each package has been received.
- Claims are not viewed by the human eye during the data validation process. To optimize the accuracy of claims, it is viewed by the OCR system. This ensures that all data transmits systematically vs human intervention of the data. During this process, it also validates provider/patient information, eligibility, covered services, and so on, for claim adjudication in accordance with State and Federal requirements.

4.2 Tips for Submitting Paper Claims

The guidelines below must be followed to prevent claims from being returned. Listed are basic tips on submitting paper claims so that they can be processed in a timely manner:

- Use only Flint OCR red drop-out (J6983 or exact match) forms that are approved CMS-1500 forms. Approved forms will be notated with the statement "APPROVED OMB NO-0938-1197 FORM 1500 (02-12)" which is listed at the bottom right hand side of the form. The National Uniform Claims Committee (NUCC) Template No. will be located at the bottom center with its version number (for example, CR061653)
- Photocopied (colored/black and white) claims and/or EOB's/EOMB's will be returned to the provider unprocessed.
- Use a legible dark ink; 10- or 12-point font in all CAPITAL/UPPERCASE in either COURIER NEW or TIMES NEW ROMAN font.
- Claims and all associated EOB's/EOMB's must be legible.
- Do not handwrite, circle, underline, or highlight any information on the claim or EOB/EOMB.
- Do a print test and review claims prior to submission to ensure claim fields are displayed with proper alignment. Data should not fall outside the designed field.
- Smudges, mark-through, stamps and pre-printed data in the body of the claim renders the legibility of claims and are considered extraneous information on the claim.
- When submitting paper claims, the use of paper clips is the preferred method of securing documentation, as staples impacts the manual handling/review process
- Do not use tape or glue to fix a claim form or attachments.
- Do not use correction fluid/tape.

- Do not submit negative charges on the claim or EOB/EOMB.
- All providers must be registered with TennCare in order to obtain payment. A valid NPI is required and must be indicated in the appropriate box on all claims submitted to TennCare.
- When submitting a claim with a NPI number that is assigned to more than one service facility, complete Box 33A with the "ZZ" qualifier and taxonomy number.
- Required fields cannot be left blank.
- Do not abbreviate fields, as they should be completed to its entirety. Improvising by typing the word "SAME" in a field (for example, insured's address is the same as the patient's address), will result in the claim being non-processable.
- All claims must include a legible copy of the Medicare EOB/EOMB and TPL EOB, when applicable.
- Submit the appropriate documentation and forms to support when TPL or Timely Filing is applied. This includes a cover letter indicating which you are requesting, as well as indication on the envelope at the time of submission (for example, O/R Timely Filing or TPL Claim Enclosed)
- All comparable information on the claim form must match the EOB/EOMB. Including one of the following NPI's: Billing, Rendering, Service Facility, or Referring.
- The EOB/EOMB submitted is required and needs to match the claim.
- The following fields are required to be visible on the EOB/EOMB:
    - Paid Date
    - "From" and "To" Service Dates
    - Billed Amount
    - Procedure Codes
    - Modifiers
    - Allowed Amount
    - Deductible Amount
    - Coinsurance/Copay Amount
    - Medicare Paid Amount
- When submitting Health Maintenance Organization (HMO) claims, ensure a cover letter is submitted for each claim stating, "Special Handle, Medicare Advantage Plan". This will ensure that your claim is adjudicated correctly.

Did you know?

- The TennCare standard font is specific for a reason. The letter "I" (i) makes all the difference in the determination from the mistake of "1". Notice how the "I" in Arial font and the "I" in Times New Roman look. The "I" in Arial can easily be mistaken for a "1" when read by the OCR scanner whereas the "I" in Times New Roman has the dashes on the top and bottom to distinguish it from "1".

- The requirement for claims to be submitted in ALL CAPS/UPPERCASE is similar to the reason above; whereas a lower case "L" (l) can be misinterpreted for an uppercase (i) "I".

Below are helpful links:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

https://bookstore.gpo.gov/search/products/site/collections%20cms1500%20form%20jsp?keywords=cms1500

Printing Specifications:

http://www.nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2019_07-v7.pdf

4.3 Returned to Provider Claims

Claims that fail to meet submission guidelines are returned to the provider. DXC Technology receives paper claim submissions twice daily during the mail postal runs to ensure claims are received in a timely manner. Reviewing criteria beforehand determines if a claim can be processed efficiently within the data validation process without any hindrance. Trained specialists review claims, according to State and Federal regulations, to ensure that submissions adhere to new day claim guidelines for TennCare processing. Any claim that fails the basic rules and regulations will be RTP'd back to the provider with an RTP sheet explaining any pertinent data that may not adhere to the guidelines.

To ensure complete traceability, the claim is scanned with a document control number (DCN) to refer back when a provider has questions about their claims.

4.4 Claim Requirement Guidelines

The Division of TennCare has tailored submission guidelines, which is entirely unique to the TennCare program, referenced in Appendix B, "CMS-1500 Claim Form". Any claim that fails to meet these guidelines is not suitable for processing and will either be RTP'd or denied in the claims' adjudication process.

Manuals and mandates have been filed and verified through the Division of TennCare in which our contracted support (DXC Technology) are required to uphold. Doing so streamlines the process in which "clean claims" can be paid in a timely manner. A "clean claim" is defined as a claim the meets the guidelines and fully adjudicates to a paid or denied status in the TennCare Management Information System (TCMIS) within 30 days.

An "unclean" claim can take a longer time to process due to system editing failure in the TCMIS. These claims with this criterion stop in the adjudication process and are placed in a "suspended" status. Meaning that they have to be manually researched and reviewed in order to determine if a claim can continue through the adjudication process to reach a paid or denied status, for example, a provider's NPI on the submitted claim being processed matches the NPI on file but has a different taxonomy.

5 Processing Claims

The Administrative Simplification Compliance Act (ASCA) requires that as of October 16, 2003, all initial Medicare claims be submitted electronically, except in limited situations. Medicare is prohibited from payment of claims submitted on a paper claim form that do not meet the limited exception criteria.

Centers for Medicare & Medicaid Services (CMS) has provided a list of exceptions to electronic claim submission on its ASCA Self-Assessment External Website Web page https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html

Some of these reasons include:

- Small Provider Claims: The word "provider" is being used generically here to refer to physicians, suppliers, and other providers of health care services.
    - Providers that have fewer than 25 full-time equivalent employees (FTEs) and that are required to bill a Medicare intermediary are considered to be small.
    - Physicians and suppliers with fewer than 10 FTEs and that are required to bill a Medicare Administrative Contractor (MAC) or Durable Medical Equipment (DME) are classified as small.
- Claims for payment under a Medicare demonstration project that specifies paper submission.
- Claims from providers that submit fewer than 10 claims per month on average during a calendar year.

Claims for TennCare recipients who have a Dual Special Needs Plan (DSNP) as a replacement for their traditional Medicare are now submitted electronically by the recipients' respective DSNP plan. The initial claim CANNOT be submitted on paper. Adjustments can be submitted electronically or on paper.

The Division of TennCare is required to process claims per the Committee on Operating Rules for Information Exchange (CORE) regulations. Per the National Uniform Claim Committee (NUCC) standards, all paper claims are to be aligned and processed per the electronic 837P transaction. Providers may notice more claims being returned due to the CORE and NUCC standard.

Claims go through a determination process once received in the mail or electronically. After meeting the basic requirements needed to process a claim, the paper claim is then scanned to create a digital image of the text. It then uses software to store the data fields of the claim in a repository for future references. During the scanning process, it then receives an internal control number (ICN) in order to track the claim in the adjudication process.

Note: Electronic claims do not have an image for reference, thus they only have the ICN for reference.

The ICN is used for the following:

- To document the source of submission (electronic, web, or paper), identified by the first two (2) digits of the ICN.
    - Electronic claims are identified by "20", "28", or "30". These claims are NOT eligible for reprocess as they were submitted via Secure File Transfer Protocol (SFTP).
    - Paper claims are identified by "10", "11", "90", "91", or "92". These claims are eligible for reprocess as long as there is an error/issue associated with the claim due to the fault of TennCare/DXC Technology during the data validation process.
- To track the claim from system entry to adjudication finalization.

The ICN is populated on the Tennessee Medicaid Remittance Advice (both 835 and Provider PDMS Portal [PDF version]) and is the source of reference for claim status inquiries.

5.1 Crossover Claims

TennCare receives Medicare crossover claims directly from Medicare's Coordination of Benefits Agreements (COBA) if the provider has elected for this service.

What is the process?

For recipients who have dual eligibility (Medicare and Medicaid), providers will bill claims to Medicare. Medicare will automatically send the claim data to TennCare for processing and payment of the deductible/coinsurance or co-pay amounts (also known as the Medicare Patient Responsibility). TennCare will deny the claim if a claim is crossed over with no patient responsibility.

Providers are urged to review their Medicare remittances to determine whether their claims have been crossed over to TennCare for processing. Claims that are indicated on the Tennessee Medical Assistance Program's remittance advice (RA) as a crossover (for example, the first two digits of the ICN read 20 or 30) should not be submitted to TennCare as a paper claim.

5.2 Third Party Liability Claims

What is Third Party Liability?

In most cases, when a recipient has TennCare they may also have other (usually private) insurance. The other insurance is sometimes called "third party liability" or "TPL." It simply means that a third party—someone besides the recipient (or their family member or conservator) may have primary responsibility for paying for covered services.

When a recipient applies for TennCare, they must report any TPL they have. If a recipient gets other insurance after they are enrolled in TennCare, they are required to notify TennCare of the other insurance.

If a recipient has other insurance (or TPL), TennCare can only process for services** that are not covered by the other insurance, or that the other insurance doesn't pay "in full." This may or may not include services where the recipient's other insurance says they must pay or has a co-pay or deductible due.

**While the provider may bill a service, all services are not covered by TennCare.

5.2.1 How TPL Works for Most TennCare Services

For most TennCare services (like hospital and doctor visits), if a recipient has TPL, the provider who rendered the service must bill the other insurance company first before TennCare can process a claim for that service. If the other insurance doesn't pay the full amount due, the provider can send a claim to TennCare. The provider must include, with its claim to TennCare, the EOB from the other insurance, showing if the service was covered, and if so, the amount the other insurance paid for the service.

TennCare will then process a claim for the balance due for that service, however if the process finds that the recipient has TPL information in the TCMIS system, the claim will process to a denied status indicating that a TPL is on file. The TPL denial will post to the provider's remittance advice, including the information for the third-party insurance.

For example, Third Party Carrier Liability Data

Insured Policy No: ABC9999 Name of Insured: Doe, John

Carrier Name: XYZ Health | Group Policy Number: EFG99999

Carrier Address: 123 Durry Lane | Group Employer Name: XYZ Health

Nashville, TN 99999

The amount TennCare pays will be no more than TennCare would have paid if the recipient didn't have TPL, but the provider must accept that amount as payment in full, even if the TennCare payment is zero. Providers cannot bill a TennCare recipient for any balance due.

5.2.2 TennCare's TPL Contractor

TennCare has a contractor who helps collect TPL from other insurance companies for services provided to TennCare members. The contractor's name is Health Management Services (HMS). Any payment received from the work HMS does is used to help offset the cost of Medicaid services TennCare has paid for.

5.3 Claim Adjudication

Paper claims are reviewed to ensure they contain all the information needed to systematically process. Claims missing required information are returned to the provider with a letter explaining the reason(s) for return. Providers may refer to Appendix B for an example of the *Return to Provider* letter.

Upon completing the review, the system assigns each claim a status: paid, denied, or suspended.

Adjudicated "clean" claims (paid or denied) are processed through the weekly financial cycle, at which time a RA 835 is produced, and payments are processed, if applicable. Claims that adjudicate before 5:00 PM CST on Tuesday will be included on the Friday RA/835 of the same week.

Claims approved for payment are issued by check or by Electronic Funds Transfer (EFT) transaction, according to the State of Tennessee Department of Treasury Guidelines.

TennCare's pricing methodology is applied to all claims that meet payment adjudication criteria. Claim payments are reduced when a TPL and/or patient liability amount (applicable for LTSS only) is present on a claim.

5.3.1 Pricing/Payment Methodology

Professional Crossover claims are billed using HIPAA 837P transactions. Professional crossover claims are for recipients with dual eligibility, Medicare, and Medicaid.

Professional Crossover claims are billed to the Division of TennCare by Medicare and DSNP's and are processed as Fee-for-Service (FFS) claims in TCMIS. Payment for these services is to the individual/billing providers.

TennCare's fiscal year is from July 1st through June 30th.

Pricing Information

Effective 7/1/2009 dates of service, the following pricing method has been applied to all Professional Crossover claims.

TennCare has four (4) methods to price Professional Outpatient crossover claims and a single claim may have more than one pricing method on the detail lines:

1. Min of Max Fee, Medicare Allowed
2. Percent of Medicare Allowed

3. 100% of Billed Charges
4. PCP Increase - E&M and VFC

Max Fee = Maximum fee from Max Fee table based on procedure code and pricing modifier
Medicaid Max Fee = Lesser of (1) Max Fee defined above times the number of units or (2) 85% of Medicare Allowed Amount from the claim
Medicaid Allowable = Lesser of (1) Medicaid Max Fee minus Medicare Payment or (2) Billed Coinsurance plus Deductible plus Psych
Medicaid Payment = Medicaid Allowable minus TPL Amount

- Claims where the Max Fee table contains the lesser Medicaid Max Fee amount will price using the Min of Max Fee, Medicare Allowed methodology.

Min of Max Fee, Medicare Allowed Example:

Detail Line & HCPCS	Max Fee Amount	Number of Units	Medicare Allowed Amount	Medicare Paid	Payment
1 – A0428	$ 155.94	1.0	$ 186.73	$ 148.78	$ 7.16
2 – A0425	$ 5.46	1.1	$ 7.10	$ 5.66	$ .35
Totals	**$ 160.92**		**$ 193.83**	**$ 154.44**	**$ 7.51**

Detail Line 1

Max Fee	Allowed Amount
$ 155.94	$ 186.73
- 148.78	* 85%
$ 7.16	$ 158.72
	- 148.78
	$ 9.94

Detail Line 2

Max Fee	Allowed Amount
$ 5.46	$ 7.10
*1.1 units	* 85%
$ 6.01	$ 6.04
- 5.66	- 5.66
$ .35	$ .38

- Claims where 85% of the Medicare Allowed Amount is the lesser of will price using the Percent of Medicare Allowed methodology.
- Anesthesia procedure codes (HCPCS codes within the range of 00100 through 01999 that have a BETOS classification of “P0”) will price using 85% of Medicare Allowed Amount (Percent of Medicare Allowed methodology).

Percent of Medicare Allowed Example:

HCPCS Code 99233 Max Fee Amount	Medicare Allowed Amount	Medicare Paid	Payment
$ 74.20	$ 84.12	$ 67.02	$ 4.48

Max Fee
$ 74.20
\- 67.02
$ 7.18

Medicare Allowed Amount
$ 84.12
* 85%
$ 71.50
\- 67.02
$ 4.48

- If the provider type equals 24 (pharmacy) and the procedure code is an injectable procedure code, the service will be priced at 100% of billed charges (deductible amount + coinsurance amount +psych amount). These claims will price using the 100% of Billed Charges.
- If the provider type equals 25 (DME/Medical Supply Dealer) and the procedure code is classified as an injectable procedure code, the service will be priced at 100% of billed charges (deductible amount + coinsurance amount + psych amount). These claims will price using the 100% of Billed Charges.

100% of Billed Charges Example:

HCPCS Code J7192 Max Fee Amount	Coinsurance Amount	Medicare Allowed Amount	Medicare Paid	Payment
$ .90	$ 809.45	$ 4,047.26	$3,237.81	$ 809.45

Medicare Allowed Amount	$4,047.26
Medicare Paid Amount	- 3,237.81
TennCare Payment	**$ 809.45**

5.4 Suspended Claims

The definition of a suspended claim is an “unclean claim” that has failed validation during the claim adjudication process. These claims are delayed in adjudicating to a paid or denied status based on systems validation versus claim information. Claims have to be manually researched and reviewed in receipt date order to determine if a claim will be adjudicated to a paid or denied status. For example, a claim is submitted with the spouse’s Social Security Number (SSN) and the linked account is not in the insured’s name, this results in a patient’s SSN mismatch.

Note: Claims can suspend multiple times during verification before final adjudication of paid or denied.

Did you know?

- If an electronic claim is processed by Medicare, then Medicare will automatically crossover an electronic claim to TennCare on your behalf if you have signed up for this service. If you would like to sign up for this service, visit www.tn.gov/tenncare.
- When an electronic claim is submitted, and a paper claim is also mailed, the electronic version will always reach a paid, denied, or suspended status first. The paper claim will take longer to process and will deny as a duplicate because of the electronic version that is on file. DO NOT submit a paper claim to the Division of TennCare if an electronic version has been submitted.

5.5 Reprocessing Claims

Per TennCare, "A reprocess should occur when there is an error/issue on our (TennCare/DXC) side (for example, keying error, a void of a paper claim that should have been an adjustment, a system issue that has a work request tied to it, etc.). A billing error/issue on the provider side does not constitute as a reprocess. The provider will need to resubmit a new red dropout claim with all updated and pertinent information so that the claim can adjudicate correctly."

Common reprocess requests:

- Keying/Scanning error
- Alignment issue (invalid claim forms)
- Invalid information (light print skews data)

5.6 Timely Filing Limits

Medicare crossover claims are usually sent to TennCare by the Medicare Coordination of Benefits Contractor and Dual Special Needs Plans. However, there are occasions when providers may submit Medicare crossover claims directly to TennCare utilizing the appropriate paper claim form.

If the Medicare claim did not automatically cross over to TennCare, and the claim is outside of the one-year timely filing limit, the provider has six months from the date he/she was notified by Medicare of payment or denial of his/her claim to submit his/her request for crossover payment directly to TennCare.

TennCare may consider exceptions to the submission deadline only in the following circumstances:

- Recipient eligibility is determined retroactively. Claims must be submitted within two years from the date in which the recipient's eligibility is added to the TennCare system.
- A Medicare claim that does not automatically crossover to TennCare. Once the claim is processed by Medicare, the provider has six months from the Medicare paid date to submit the claim to TennCare.
- Denied claims must be resubmitted within six months from the date the claim was originally denied and if the claim does not adjudicate at this time, a follow up must be done every six months thereafter until the claim has adjudicated. This will ensure that claims will adjudicate within the timely filing guidelines.
- Claims submitted due to third party coverage must be submitted within 60 days of the TPL payment and if the claim does not adjudicate at this time, a follow up must

be done every six months thereafter until the claim has adjudicated. This will ensure that claims will adjudicate within the timely filing guidelines.

Follow-up paper submissions must include the original claim(s) and EOMB(s) that were denied as proof of Timely Filing, failure to do so will result in a denial. RA's can also be used as proof.

5.6.1 Top Paper Claim Rejection Reasons

- Light print on claim form
- Invalid font
- Alignment issue with claim
- Billing and/or secondary NPI not on file
- Diagnosis/Procedure code not on file
- Total Charges do not equal to the sum of the last page
- EOB/EOMB not attached
- EOB/EOMB does not match claim
- NPI on EOMB does not match to claim
- Invalid recipient identifier/number (RID)

5.6.2 Top Suspended Reasons

- Recipient name and number disagree (paper submissions)
- Recipient number not on file (paper submissions)
- Suspect duplicate - Detail
- Recipient covered by private insurance (paper submissions)
- Units of service must be greater than zero (paper Submissions)
- Medicare deductible greater than maximum
- Medicare allowed amount missing
- Patient has two coverage types
- Medicare coinsurance amount greater than amount paid by Medicare
- First modifier invalid

5.6.3 Top Denial Reasons

- No crossover coinsurance/deductible due - detail
- Medicare allowed amount missing
- Timely filing limit exceeded
- Recipient number not on file (electronic submissions)
- Recipient name and number disagree (electronic submissions)
- Recipient covered by private insurance (electronic submissions)
- Units of service must be greater than zero (electronic submissions)
- Place of service (POS) is invalid

6 Adjustments/Void Request Form

Adjustment/Void claims are submitted when it is necessary to change information on a previously processed claim. The change must impact the processing of the original bill or additional bills in order for the adjustment to be performed. The claim being adjusted must be in a finalized paid status.

If a claim in a paid status has been reviewed by TennCare and has one or more line-items denied, adjustments can be made to the paid line items.

Note: Adjustments cannot be made to any part of a denied line item on a partially paid claim.

The Adjustment/Void Request Form allows the Division of TennCare to correct or annul payments. All requests must be submitted on the most current version. Adjustments or voids submitted on any other version will be returned to the provider, for the claims will be unsuitable for processing.

Providers have two (2) years from the date the claim was originally paid to submit an adjustment for processing.

Reasons for the submission of an Adjustment/Void request may include, but are not limited to the following:

- Overpayments/Refunds
- Underpayments
- Payments for an incorrect procedure code(s)
- Incorrect number of units

The Adjustment/Void Request Form can be located on the TennCare website:

https://www.tn.gov/content/dam/tn/tenncare/documents/avform.pdf

6.1 Adjustment/Void Request Form Submission Guidelines

The Adjustment/Void Request Form is required for each claim ICN to be adjusted or voided.

Claims requiring a change to the provider number (NPI or Billing Number) must be voided and a new CMS 1500 claim form submitted with the correct provider information. Adjustment/Void forms missing information will be returned to the provider unprocessed.

All completed Adjustment/Void Request Forms must be sent to the following address:

State of Tennessee
Division of TennCare
P.O. Box 1700
Nashville, TN 37202-1700

Providers may refer to Appendix B for a sample Adjustment/Void Request Form and completion instructions.

7 Overpayments/Refunds

Refunds are voluntary payments made to TennCare by providers due to overpayments. When submitting a refund:

- Complete an Adjustment/Void Request Form to include checking the box labeled "Overpayment – Refund Check Attached"*.*
- Submit pertinent supporting documentation, including, but not limited to:
  - Medicare EOMB
  - TPL EOMB
- Include a check made payable to the State of Tennessee.

Refunds must be sent to the following address:

State of Tennessee, Division of TennCare
Attention: Division of Budget/Finance
310 Great Circle Road
Nashville, TN37243-1700

Refund amounts for claims paid by an active Managed Care Organization/Managed Care Contractor (MCO/MCC) will be returned. Refunds for these claims should be sent to the respective TennCare MCO/MCC that made the original payment.

Refund amounts for claims paid by an inactive MCO/MCC will be processed by TennCare.

8 Appeals

Providers who have filed claims with TennCare directly and who believe they have not been paid correctly have certain appeal rights, in accordance with TennCare Rule 1200-13-18.

Claims may be appealable if they were filed in accordance with TennCare rules and policies and they meet certain basic criteria. These criteria include, but are not limited to, the following:

- The claim was a "clean claim".
- The claim contained no errors, such as incorrect dates, codes, etc.
- The claim was filed timely. See Policy PAY 13-001 at for timely filing policies.
- The claim was for a covered service.
- The claim was for a service delivered to an eligible recipient.
- The claim was processed in accordance with Federal and TennCare rules and policies.
- The claim was processed correctly by the TennCare Vendor, which includes accurately scanning, keying, and manual adjudication of suspended claims/audits.

There are certain types of claims for which no appeal will be provided. These include, but are not limited to, claims that do not meet one or more of the criteria stated above. As a general rule of thumb, a claim that was denied because it does not meet the above criteria is not appealable.

After reviewing a claim, one of three decisions will be made:

- The claim should have been paid as requested.
- The claim is not appealable, and no reimbursement will be made.
- The claim is appealable, and changes in reimbursement may be made, depending upon the outcome of the appeal.

Procedures

1. Provider appeals will be mailed to the attention of the Claims Unit Manager at the following address:

Division of TennCare
310 Great Circle Rd.
Nashville, TN 37243

2. The Claims Unit will review and research the claim to determine which of the above three decisions is appropriate. They will check for keying errors or general processing errors that may have occurred in the TennCare system, in addition to validating that a clean claim was submitted appropriately by the provider within the timely filing guidelines and that the required follow-up was performed in accordance with the rules/regulations/policies.
3. If the decision is that the claim should have been paid as requested, the Claims Unit will take appropriate action to pay the claim. The Claims Unit will use the Resolvable Appeal template to respond to the provider.
4. If the decision is that the claim is not resolvable, as defined above, the Claims Unit will consult with the Office of General Counsel on the matter of correspondence to the provider—appropriate citations, specific verbiage, etc. and will utilize either the Denied Claim Response to Provider – No Appeal Rights **OR** the Denied Claim Response to Provider – Appeal Rights template notice to respond to the provider. The correspondence will be sent to the provider via certified mail.
5. If the claim appears to be appealable, as defined above, the Claims Unit will notify the provider of the opportunity to appeal. This notification letter will contain the information the provider is to include in a request for an appeal, the deadline for communicating the request for an appeal to the Claims Unit, and the address for the Claims Unit. When a request for an appeal is received, the documents and the envelope in which they were received from the provider will be dated, then scanned and saved for Claims Unit files. The originals will be hand-delivered to the Office of General Counsel's State Litigation Unit. An appeal request received from a provider is time-sensitive and must be delivered to the Office of General Counsel on the date of receipt.
6. At that point, the Office of General Counsel will take over handling the appeal. Claims Unit staff will be available to assist as needed.

Appendix A Glossary

Table A: Glossary

Term	Definition
837P	Electronic Professional Claim - HIPAA Compliance of Claim Processing through the Electronic Billing of Third-Party Insurance Claims
AMA	American Medical Association
ASCA	Administrative Simplification Compliance Act
BLK Lung	Black Lung
CCYY	Year, indicated entry of four digits for the year
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services, formerly HCFA
CMS-1500	Centers for Medicare and Medicaid Services Form 1500 – The common claim form used by professionals to bill for services
COBA	Coordination of Benefits Agreements
COBC	Coordination of Benefits Contractor
CPT ®	Current Procedural Terminology, 4th Edition
Crossover Claim	A claim for services rendered to a patient eligible for benefits under both Medicare and Medicaid Programs
DD	Day, indicated entry of two digits for the day
DME	Durable Medical Equipment
DOS	Date of Service
DOB	Date of Birth
DSNP	Dual Special Needs Plan
DXC	DXC Technology
EFT	Electronic Funds Transfer
EMG	Emergency
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early & Periodic Screening, Diagnosis, and Treatment
F	Female
FECA	Federal Employee's Compensation Act
FFS	Fee-for-Service
GTIN	Global Trade Item Number
HCFA	Health Care Financing Administration, currently CMS
HCPCS	Healthcare Common Procedural Coding System
HIBCC	Health Industry Business Communications Council
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICN	Internal Control Number
I.D. or ID	Identification
I.D.# or ID#	Identification Number
INFO	Information
LMP	Last Menstrual Period

Term	Definition
M	Male
MCC	Managed Care Contractor
MCO	Managed Care Organization
MM	Month, indicated entry of two digits for the month
NDC	National Drug Codes
No.	Number
NPI	National Provider Identifier
NUCC	National Uniform Claim Committee
NUCC-DS	National Uniform Claim Committee Data Set
OCR	Optical Character Recognition
OMB	Office of Management and Budget
OZ	Product number Health Care Uniform Code Council
PH#	Phone Number
PDMS	Provider Database Management System
POS	Place of Service
Qual.	Qualifier
RA	Remittance Advice
REF.	Reference
RID	Recipient Identification Number
RTP	Returned to Provider
SFTP	Secure File Transfer Protocol
SOF	Signature on File
SSN	Social Security Number
TFCA	Tennessee False Claims Act
TCMIS	TennCare Management Information System
TPL	Third Party Liability
UPC	Universal Product Code
UPIN	Unique Physician Identification Number
USIN	Unique Supplier Identification Number
VP	Vendor Product Number
YY	Year, indicates entry of two digits for the year

Appendix B: CMS-1500 Claim Form

B.1 CMS-1500 Claim Form Completion Instructions

The instructions describe information that must be entered in each item of the 1500 Claim Form. Item numbers ***not*** referenced are ***not*** needed to adjudicate the claim form.

These instructions are tailored for submitting claims to TennCare. For complete claim submission instructions, refer to the National UB-04 Uniform Billing Manual prepared by the National Uniform Claim Committee (NUCC). The National Uniform Claim Committee Manual contains important coding information not available in these instructions. Providers may view the manual by accessing the NUCC website at http://www.nucc.org/

Item Number 1 – Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other" [required]

Indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked, which should be "Medicaid".

Item Number 1a – Insured's ID Number [required]

Enter the insured's SSN or if the patient has a unique Recipient Identification Number (RID) assigned by the payer, then enter that number in this field.

Item Number 2 – Patient's Name [required]

Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (for example, Jr., Sr.), enter it after the last name and before the first name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Note *– Titles (for example, Sister, Capt., Dr.) and professional suffixes (for example, PhD, MD, Esq.) should not be included with the name.*

Item Number 3 – Patient's Birth Date, Sex [required]

Enter the patient's 8-digit birth date (MM|DD|CCYY). Enter an X in the correct box to indicate the sex (gender) of the patient. Only one box can be marked. If the sex is unknown, leave blank.

Item Number 4 – Insured's Name [required]

Enter the insured's full last name, first name, and middle initial. If the person uses a last name suffix (for example, Jr., Sr.), enter it after the last name and before the first name.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Note *– DO NOT write in "SAME" if the Insured's Name is the same as the Patient's Name. Type in the Insured's full name.*

Item Number 5 – Patient's Address [multiple fields] [required]

Enter the patient's mailing address. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code, and Telephone Number.

Item Number 6 – Patient Relationship to Insured [required]

Enter an X in the correct box to indicate the patient's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 7 – Insured's Address [multiple fields] [required]

Enter the insured's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code, and Telephone Number.

<u>Item Number 9</u> – Other Insured's Name (situational)

If Item Number 11d is marked "YES", complete fields 9, 9a, AND 9d. If marked "NO", no data should be entered.

When additional group health coverage exists, enter the insured's full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2.

Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

<u>Item Number 9a</u> – Other Insured's Policy or Group Number (situational)

Enter the policy or group number of the other insured. Do not use a hyphen or space as a separator within the policy or group number.

<u>Item Number 9d</u> – Insurance Plan Name or Program Name (situational)

Enter the other insured's insurance plan or program name.

<u>Item Numbers 10a-10c</u> – Is Patient's Condition Related To (situational)

When appropriate, enter an X in the correct box to indicate whether one or more of the services described are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance. Insurance information must then be indicated in Item Number 11d.

<u>Item Number 10d</u> – Claim Codes [Designated by NUCC] (situational)

When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc.org under Code Sets.

<u>Item Number 11d</u> – Is there Another Health Benefit Plan? [required]

When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, AND 9d. Only one box can be marked.

***Note** – A copy of the TPL payer explanation of benefits (EOB) must also be attached along with the Medicare EOB.*

<u>Item Number 12</u> – Patient's or Authorized Person's Signature [required]

Enter "Signature on File," "SOF," or a legal signature. When there is a legal signature, enter the date signed in 6-digit (MM|DD|YY) or 8-digit (MM|DD|CCYY) format.

<u>Item Number 13</u> – Insured's or Authorized Person's Signature [required]

Enter "Signature on File," "SOF," or a legal signature.

<u>Item Number 14</u> – Date of Current Illness, Injury, or Pregnancy? [LMP] (situational)

Enter the 6-digit (MM|DD|YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

Enter the applicable qualifier to identify which date is being reported.

431 Onset of Current Symptoms or Illness

484 Last Menstrual Period

Enter the qualifier to the right of the vertical dotted line.

Item Number 15 – Other Date (situational)

Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) format.

Enter the applicable qualifier to identify which date is being reported.

454 Initial Treatment

304 Latest Visit or Consultation

453 Acute Manifestation of a Chronic Condition

439 Accident

455 Last X-ray

471 Prescription

090 Report Start (Assumed Care Date)

091 Report End (Relinquished Care Date)

444 First Visit or Consultation

Enter the qualifier between the left-hand set of vertical dotted lines.

Item Number 16 – Dates Patient Unable to Work in Current Occupation (situational)

If the patient is employed and is unable to work in their current occupation, a 6-digit (MM|DD|YY) date must be shown for the "From – To" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

Item Number 17 – Name of Referring Provider or Other Source (situational)

Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider

DK Ordering Provider

DQ Supervising Provider

Enter the qualifier to the left of the vertical dotted line.

Item Number 17a AND 17b [Split Field]

***Title 17a*: Other ID# (situational)**

The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.
The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)

***Title 17b: NPI#* [required]**

If applicable, enter the NPI number of the referring, ordering, or supervising provider provided when Item Number 17 is filled out.

<u>Item Number 18</u> – Hospitalization Dates Related to Current Services (situational)

Enter the inpatient 6-digit (MM|DD|YY) hospital admission date followed by the discharge date (if discharge has occurred).

If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

<u>Item Number 19</u> – Additional Claim Information (situational)

Please refer to the most current instructions from the public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number (This qualifier is used for Supervising Provider only.)
N5	Provider Plan Network Identification Number
SY	Social Security Number (The social security number may not be used for Medicare.)
X5	State Industrial Accident Provider Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both provider identifiers and provider taxonomy may be used in this field.

When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/information.

<u>Item Number 20</u> – Outside Lab? $Charges (situational)

Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "NO" mark or blank indicates that no purchased services are included on the claim.

If "Yes" is annotated, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

<u>Item Number 21</u> [Split Field]

Title: Diagnosis or Nature of Illness or Injury

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9 ICD-9-CM

0 ICD-10-CM

Enter the indicator between the vertical dotted lines in the upper right-hand portion of the field.

Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes as it relates to the ICD indicator. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

<u>Item Number 22</u> – Resubmission Code (situational)

List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (for example, code).

When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field.

7 Replacement of prior claim

8 Void/cancel of prior claim

This Item Number is not intended for use for original claim submissions.

<u>Item Number 23</u> – Prior Authorization Number (situational)

Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service.

SECTION 24

Supplemental information can only be entered with a corresponding completed service line. The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier and to accommodate the submission of supplemental information to support the billed service. The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. Providers must verify requirements for this supplemental information with the payer.

<u>Item Numbers 24A-24G</u> (Shaded Area)

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00

123.45

<u>Additional Information for Reporting NDC</u>

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56

2

99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2	International Unit	ME	Milligram	UN	Unit
GR	Gram	ML	Milliliter		

When reporting compound drugs, a statement of ingredients may be required to be attached to the claim.

The following qualifiers are to be used when regulations mandate the use of the Universal Product Number (UPN) for reporting medical and surgical supplies:

EN EAN/UCC - 13

EO EAN/UCC - 8

HI HIBC (Health Care Industry Bar Code)

Supplier Labeling Standard Primary Data Message

UK GTIM 14 - digit data structure

UP UCC - 12

Additional Information for Reporting Tooth Numbers and Areas of the Oral Cavity:

When reporting tooth numbers, add in the following order: qualifier, tooth number, for example, JP16. When reporting an area of the oral cavity, enter in the following order: qualifier, area of oral cavity code, for example, JO10.

When reporting multiple tooth numbers for one procedure, add in the following order: qualifier, tooth number, blank space, tooth number, blank space, tooth number, etc., for example, JP1 16 17 32.

When reporting multiple tooth numbers for one procedure, the number of units reported in 24G is the number of teeth involved in the procedure.

When reporting multiple areas of the oral cavity for one procedure, add in the following order: qualifier, oral cavity code, blank space, oral cavity code, etc., for example, JO10 20.

When reporting multiple areas of the oral cavity for one procedure, the number of units reported in 24G is the number of areas of the oral cavity involved in the procedure.

The following are the codes for tooth numbers, reported with the JP qualifier:

1 32 Permanent dentition

51 82 Permanent supernumerary dentitions

A T Primary dentition

AS TS Primary supernumerary dentition

The following are the codes for areas of the oral cavity, reported with the JO qualifier:

00 Entire oral cavity

01 Maxillary arch

02 Mandibular arch

10 Upper right quadrant

20 Upper left quadrant

30 Lower left quadrant

40 Lower right quadrant

For further information on these codes, refer to the Current Dental Terminology (CDT) Manual available from the American Dental Association.

Item Number 24a – Date(s) of Service [lines 1-6] [required]

Enter a 6-digit (MM|DD|YY) or 8-digit (MM|DD|CCYY) format "From" and "To" date for each procedure, service, or supply item. Both the "From" and "To" dates are required.

Item Number 24b – Place of Service (POS) [lines 1-6] [required]

Enter a valid 2-digit POS code for each item used or service provided. A complete list of POS codes can be found on the CMS website at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Website_POS_database.pdf

Item Number 24c – EMG [lines 1-6] (situational)

Check with the payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field.

Item Number 24d – Procedures, Services, or Supplies/Modifiers [lines 1-6] [required]/(situational)

Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-digit modifiers. The specific procedure code(s) must be shown without a narrative description.

Item Number 24e – Diagnosis Pointer [lines 1-6] [required]

Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable.

ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.

This field allows for the entry of four characters in the unshaded area. **Do not** use commas or hyphens between the letters to try to accommodate for more.

Item Number 24f - $Charges [lines 1-6] [required]

Enter the charge for each listed service.

Enter the number, right justified, in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Item Number 24g – Days or Units [lines 1-6] [required]

Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral "1" must be entered.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").

Item Number 24h – EPSDT/Family Plan [lines 1-6] (situational)

For Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) related services, enter the response in the shaded portion of the field as follows:

If there is no requirement (for example, state requirement) to report a reason code for EPSDT, enter Y for "YES" or N for "NO" only.

If there is a requirement to report a reason code for EPSDT, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The 2-character code is right justified in the shaded area of the field.

The following codes for EPSDT are used in 5010A1:

AV	Available – Not Used (Patient refused referral.)
S2	Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.)
ST	New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.)
NU	Not Used (Used when no EPSDT patient referral was given.)

If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.

Item Number 24i – ID Qualifier [lines 1-6] [required]

Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both provider identifiers and provider taxonomy may be used in this field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Item Number 24j – Rendering Provider ID # [lines 1-6] [required]

The individual rendering the service should be reported in 24J. Enter the NPI number in the unshaded area of the field.

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here.

Item Number 25 – Federal Tax ID Number [required]

Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.

Do NOT enter hyphens with numbers. Enter numbers left justified in the field.

Item Number 26 – Patient's Account No. [required]

Enter the patient's account number assigned by the provider of service's or supplier's accounting system.

Do NOT enter hyphens with numbers. Enter numbers left justified in the field.

Item Number 27 – Accept Assignment? [required]

Enter an X in the correct box. Only one box can be marked. Report "Accept Assignment?" for all payers.

Item Number 28 – Total Charge [required]

Enter total charges for the services (for example, total of all charges reported in 24F).

Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

***Note** – When submitting a multiple page claim, **ONLY THE LAST PAGE** of the claim should contain the total for the entire claim. Totals labeled for each page delays the claim for adjudication.*

Item Number 29 – Amount Paid (situational)

Enter the total amount the patient and/or other payers paid on the covered services only.

Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

Item Number 31 – Signature of Physician or Supplier Including Degrees or Credentials [required]

The provider or authorized representative must sign Item 31. In addition, the date the form was signed is also required (enter the 6-digit date [MM/DD/YY], 8-digit date [MM/DD/CCYY], or alpha-numeric date [for example, January 18, 2012]).

Item Number 32 – Service Facility Location Information [required]

Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests.

If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider.

Enter the name and address information in the following format:

1st Line – Name

2nd Line – Address

3rd Line – City, State and ZIP Code

Do not use punctuation (for example, commas, periods) or other symbols in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report the 9-digit ZIP code, including the hyphen.

If reporting a foreign address, contact payer for specific reporting instructions.

<u>Item Number 32a</u> –NPI# [required]

Enter the NPI number of the service facility location in 32a.

Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

<u>Item Number 32b</u> –Other ID# (situational)

Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

The NUCC defines the following qualifiers used in 5010A1:

0B State License Number

G2 Provider Commercial Number

LU Location Number

Item Number 33 – Billing Provider Info & Ph # [required]

Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format:

1st Line – Name

2nd Line – Address

3rd Line – City, State and ZIP Code

Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed.

Do not use punctuation (for example, commas or periods) or other symbols in the address (for example, 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report the 9-digit ZIP code, including the hyphen. Do not use a hyphen or space as a separator within the telephone number.

If reporting a foreign address, contact payer for specific reporting instructions.

5010A1 requires the "Billing Provider Address" be a street address or physical location. The NUCC recommends that the same requirements be applied here.

Item Number 33a – NPI# [required]

Enter the NPI number of the billing provider in 33a.

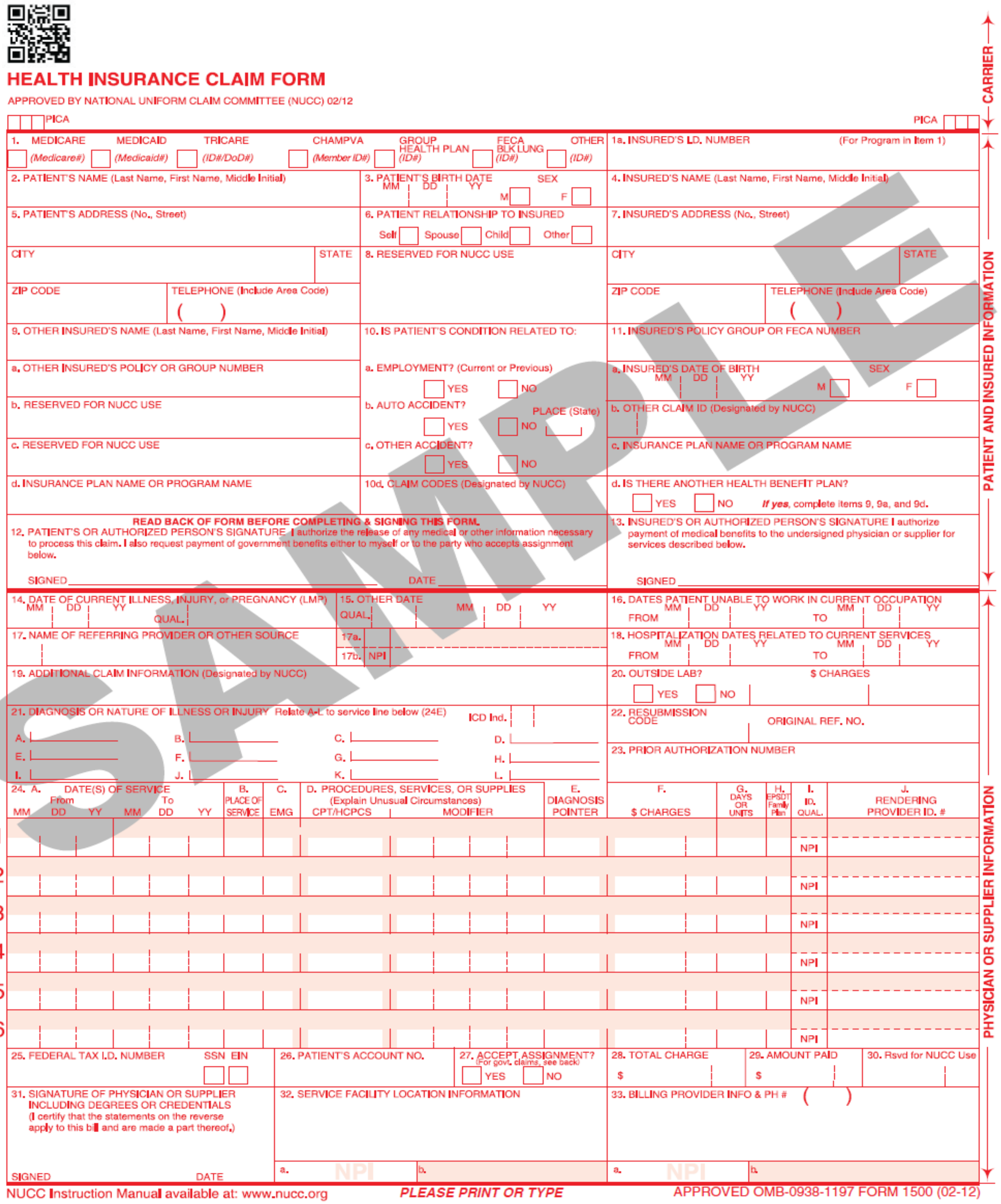
Item Number 33b – Other ID [required]

Enter the 2-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

The NUCC defines the following qualifiers used in 5010A1:

0B	State License Number
G2	Provider Commercial Number
ZZ	Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.)

The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider type, classification, and/or area of specialization. Both provider identifiers and provider taxonomy may be used in this field.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

Figure B.1: CMS-1500 Claim Form

B.2 CMS-1500 Return to Provider Letter

OCR Reject ⬭
Manual Review Reject ⬭

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF TENNCARE
P.O. Box 1700
NASHVILLE, TENNESSEE 37202-1700

Date: ____________________

Clerk Initials: ______________

☐ See back of form for more information

ATTENTION PROVIDERS:
Effective 1/1/17, please be advised that <u>TennCare has enforced national billing standards to allow clean paper claims to adjudicate</u>. Providers may notice more claims being returned due to claim processing regulations. Provider corrections and resubmission of a Returned to Provider (RTP) claim will apply a new receipt date to the claim. Consequently, providers will need to submit a new claim if this occurs. Please visit www.nucc.org for additional guidelines. Listed below are common reason codes of why claims are RTP'd for correction:

TennCare no longer accepts paper claims that are either entirely handwritten or have been corrected with handwritten data. Please refer to back of this letter for proper claims submission guidelines.

The only acceptable claim forms are the official red drop-out ink form printed in Flint OCR Red, J6983, (or exact match) ink. Use UPPERCASE, 10 or 12 point font, Courier New or Times New Roman in a legible dark black ink. This font ensures that characters have a clear definition for the Optical Character Recognition (OCR) system. (e.g. The letter 'I' (i) makes all the difference in the determination from the mistake of '1'. Notice how the 'I' in Arial font and the 'I' in Times New Roman looks.) Compliance with these standards are required to facilitate the use of image processing technology (e.g. facsimile transmission & image storing). When submitting paper claims, the use of paper clips are the preferred method of securing documentation, as staples impacts the manual handling/review process. For more information please visit www.cms.gov

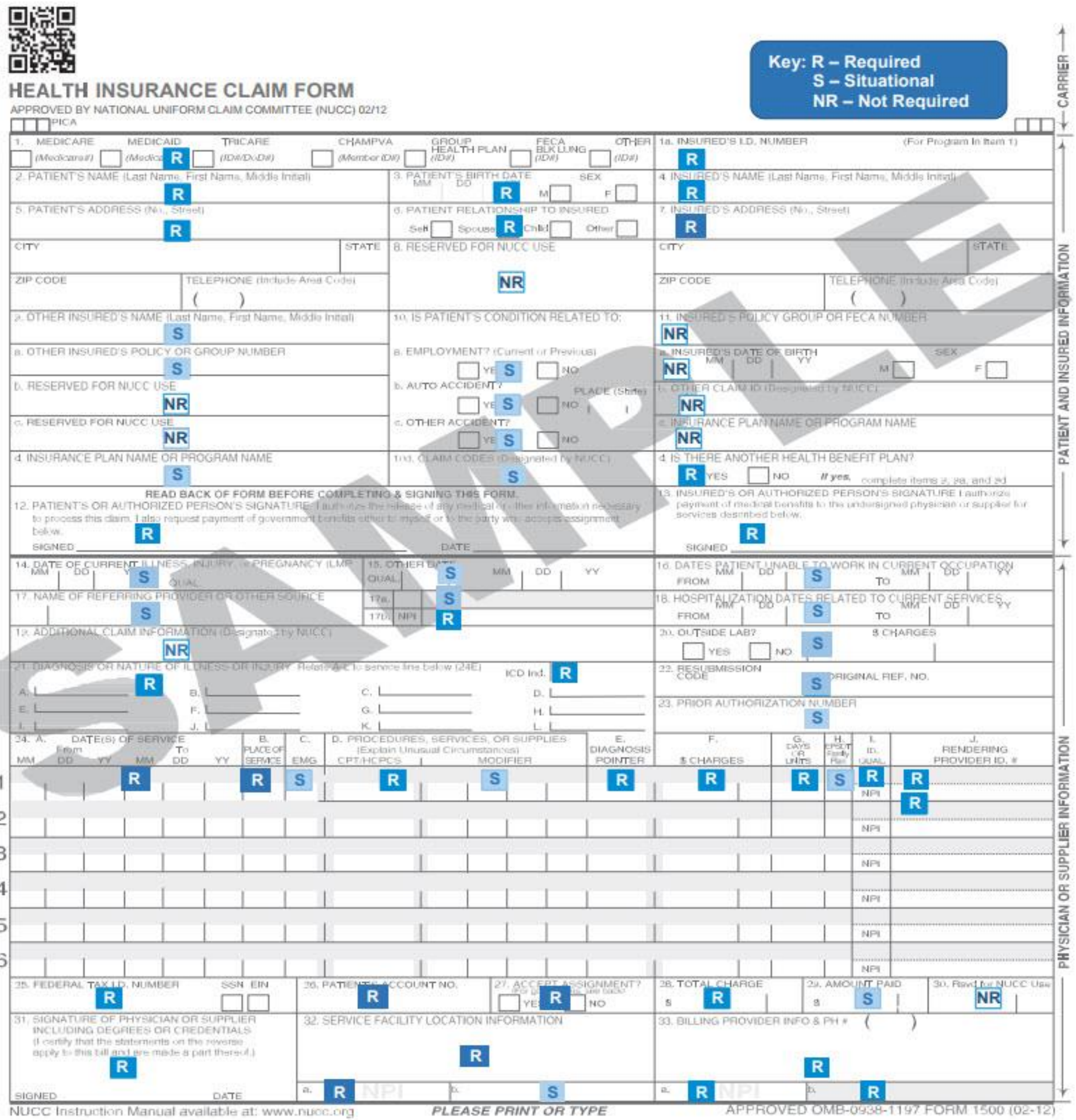
<u>REQUIRED FIELD(S)</u>
( ) Invalid Font (Lowercase, Illegible Ink [Broken/Light Characters, Bold/Bleeding/Smudged Characters])
( ) Insured's Unique ID Number Missing/Invalid (Box 1a) ***Must be 11 Digit RID or 9 Digit SSN for TennCare***
( ) Patient Name [Last name, First name] Missing (Box 2)
( ) Patient Name (Box 2) on claim form does not match Insured's Unique ID Number (Box 1a) on file
( ) Date of Birth [MM/DD/CCYY] Missing/Invalid (Box 3)
( ) Insured's Name Missing (Box 4), Patients' Address Missing (Box 5), Patient Relationship to Insured (Box 6) Missing
( ) Insured's Name, Policy/Group Number, Plan/Program [9, 9a and 9d] is present, but **'No'** is checked for Box 11d
( ) Insured's Name, Policy/Group Number, Plan/Program [9, 9a and 9d] is blank, but **'Yes'** is checked for Box 11d
( ) Insured's Name, Policy/Group Number, Plan/Program [9, 9a and 9d] is present, but no boxes are checked in Box 11d
( ) Both **'Yes'** and **'No'** are check (Box 11d)
( ) Only one choice in 'Is Patient's Condition Related To' can be checked **'Yes'** (Box 10)
( ) Patient's/Authorized Person's Signature and/or Date (Box 12) or Insured's/Authorized Person's Signature (Box 13) Missing/Invalid
( ) Date of Current Illness, Injury, or Pregnancy {LMP} or Qualifier Missing/Invalid (Box 14)
( ) Other Date or Qualifier Missing/Invalid (Box 15)
( ) Qualifier [DN, DK, DQ] or Name of Referring Provider or Other Sources Missing/Invalid (Box 17)
( ) Referring NPI Missing when Other ID # is present (17a and 17b)
( ) Referring NPI (Box 17b), Rendering NPI (Box 24j), Service Facility NPI (Box 32a), Billing NPI (Box 33a) Number Missing/Invalid
( ) ICD Indicator, Primary Diagnosis Code [21a], Secondary Diagnosis Codes [21b-l] Missing/Invalid (Box 21)
( ) Detail Line Missing (Boxes 24a-24j)
( ) From or To Date of Service Missing/Invalid (Box 24a)
( ) Place of Service Missing/Invalid (Box 24b)
( ) EMG code Invalid (Box 24c)
( ) Procedures/Services/Supplies CPT/HCPCS or Modifier Code Missing/Invalid (Box 24d)
( ) Diagnosis Pointer (Box 24e), $ Charges (Box 24f), Days or Units (Box 24g) Missing/Invalid
( ) Rendering ID Qualifier (Box 24i) and/or Rendering Provider ID {Top Portion of 24j} Missing/Invalid
( ) Federal Tax ID Number/SSN Missing/Invalid (Box 25)
( ) Patient's Account No. (Box 26) or Accept Assignment? Missing/Invalid (Box 27)
( ) Total Charge Missing or Sum of All Detail Lines Do not Equal Total Charge on Last Page of Claim (Box 28)
( ) Signature of Physician and/or Date Missing/Invalid (Box 31)
( ) Service Facility Location (Box 32) is present and different from Billing Provider (Box 33), Service Facility NPI (Box 32a) is required
( ) Billing Provider Information Missing (Box 33)
( ) Other Billing ID Qualifier and/or Number Missing/Invalid (Box 33b)
( ) Invalid claim form

<u>EOMB</u>
( ) EOMB not attached
( ) EOMB does not match claim
( ) Medicare EOMB Incomplete, Information Needed Cut Off
( ) Illegible Medicare EOMB (Bold Print, Fuzzy Print, Light Print, Small Print)
( ) Handwritten Information on EOMB
( ) Medicare Paid Date Missing/Invalid on EOMB
( ) Multiple EOMB's with different Medicare Paid Dates, Only one Paid Date is allowed for each claim
( ) EOMB Information missing (Patient Name, Date of Service, Procedure Code, Modifier, Billed Charges)
( ) EOMB Information does not match with claim (Patient Name, Date of Service, Procedure Code, Modifier, Billed Charges)
( ) Billed Charges are combined on EOMB, Negative Charges, Deductible and Coinsurance/Copay are combined on EOMB

<u>ALIGNMENT/PRINT INK</u>
( ) Forms and EOMB's must be aligned and in a dark ink print per CMS-1500 Data Element printing specifications. For more information please visit www.nucc.org

<u>OTHER</u>: ____

CMS-1500 **YOUR ASSISTANCE IN THIS MATTER IS GREATLY APPRECIATED** **Revised 01/19/18**
NCR Key: 1 2 3 4 5 6 7 8 9 10



Manually Reviewed/Non-Compliant claims:

1. Extraneous data (i.e. Stamps, Typed/Handwritten notations)
2. Billing NPI, Rendering NPI, Service Facility NPI or Federal Tax ID not matching from the claim to the EOMB
3. White out or Correction tape
4. Highlighting, Smudges or Discolorations
5. Handwritten corrections
6. Post-it notes attached
7. Submission of negative charges
8. Photocopies of the CMS-1500 claim form or EOMB
9. Submit EOMB for each claim
10. Alignment issue with claim, data not within fields

FOR CLAIM(S) INQUIRIES/STATUS, PLEASE CONTACT PROVIDER SERVICES AT: 1-800-852-2683

Figure B.2: CMS-1500 Return to Provider Letter

B.3 Adjustment/Void Request Form Completion Instructions

SECTION I – BILLING PROVIDER'S INFORMATION

1. Name

Enter the Billing provider's name.

2. NPI or Medicaid Number for Atypical Providers Only

Enter the Billing Provider's 10-digit National Provider Identifier (NPI) or 7-digit Medicaid Number for Atypical Providers Only. An Atypical provider is defined by CMS as a non-healthcare provider (e.g., taxi services and home delivered meals).

3. Phone Number

Enter the Billing Provider's phone number.

4. Contact Name

Enter the name of the authorized representative.

5. Address

Enter the Billing Provider's address.

SECTION II – CLAIM INFORMATION

6. Claim #

Enter the 13-digit claim number from the TennCare Remittance Advice (RA).

7. Remittance Advice Date

Enter the date of the RA (found at the top right corner of the RA).

8. Billed Amount

Enter the total billed amount of the claim that was submitted to TennCare.

9. Paid Amount

Enter the total paid amount.

10. Recipient ID#

Enter either the 11-digit Recipient ID (RID) or the Social Security Number (SSN) of the recipient.

11. Recipient – Name

Enter the complete name of the member for whom payment was received, as it appears on the TennCare RA.

12. From Date of Service

Enter the "From" date of service in MM/DD/CCYY format.

13. To Date of Service

Enter the "To" date of service in MM/DD/CCYY format.

SECTION III – THIRD PARTY LIABILITY Information

14. Other Insurance EOB is required.

If a recipient has other insurance, complete the Third Party Liability Update Request Form
TPL Form: https://www.tn.gov/content/dam/tn/tenncare/documents/TPLFORM.pdf

a. Insurance Company - Name of the third party company
b. Policy # - Policy number of the third party company
c. Name of Insured - Name of the member that holds the third part company policy
d. Claim # - Claim number that the third party paid under
e. Amount Paid by Third Party - Total amount paid on claim by third party

SECTION IV – TYPE OF REQUEST

Select the the appropriate button for Adjustment or Void

15. If adjustment, select one of the reasons for the request:

a. Underpayment.
b. Overpayment – Refund check attached.
c. Overpayment – Deduct from future payment.
d. TPL Payment – Other insurance EOB required.

16. Give specific reason for the adjustment or void.

SECTION V – LIABILITY AMOUNT (For Nursing Facility Providers only)

Include a copy of the 2362 form when submitting an Adjustment/Void Request form as a result of a change in the liability amount.

17. Monthly Liability Amount

Enter the recipient's monthly liability amount as shown on the 2362 form.

18. Effective Date

Enter the effective date of the liability.

SECTION VI – SIGNATURE

19. Signature

Signature of the Authorized Representative.

20. Date

Enter the date form was signed.

If you select Overpayment - Refund Check as the Adjustment Reason, send this completed form with the REFUND CHECK **State of Tennessee** **Division of TennCare** **Attention: Fiscal Budget, 4E** **310 Great Circle Road** **Nashville TN, 37243-1700**	STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION DIVISION OF TENNCARE P.O. BOX 1700 NASHVILLE, TN 37202-1700	**Send ALL OTHER completed Adjustment/Void Forms to:** **State of Tennessee** **Division of TennCare** **P.O. Box 1700** **Nashville, TN 37202-1700**

Medicaid-Title XIX Adjustment/Void Request Form

By completing this form, the provider certifies that all the information is true and correct. For questions, providers may call 1-800-852-2683. **Before completing, please read the Adjustment/Void Request Completion Instructions**.

Type or Print clearly.

SECTION I – Billing Provider's Information

1. Name	2. NPI or Medicaid ID (Atypical Providers Only)
3. Phone Number	4. Contact Name (Authorized Representative)
5. Address	

SECTION II – Claim Information – Use Information from Remittance Advice

6. Claim # (13-digits)	7. RA Date	8. Billed Amount	9. Paid Amount
10. Recipient ID#	11. Recipient – Name (Last, First, MI)	12. From Date of Service	13. To Date of Service

SECTION III – Third Party Liability Information (Other Insurance EOB Required)

14. If Adjustment or Void is due to third party payment, complete the information below. For TPL updates, compete the TPL Update Request form. TPL Form: https://www.tn.gov/content/dam/tn/tenncare/documents/TPLFORM.pdf

a. Insurance Company		b. Policy #
c. Name of Insured	d. Claim #	e. Amount Paid by Third Party

SECTION IV – Type of Request: ☐ **ADJUSTMENT** ☐ **VOID**

15. Reason for Adjustment:

a. ☐ Underpayment

b. ☐ Overpayment – Refund check attached

c. ☐ Overpayment – Deduct from future payment

d. ☐ TPL Payment – Other insurance EOB required

16. Give Description of Request:

Section V – Patient Liability Amount (For Nursing Facility Providers Only) A copy of the 2362 form is required

17. Monthly Patient Liability Amount	18. Effective Date

Section VI - Signature

I request that reprocessing of the claim be made with the information given above. I hereby certify that the above claim for services is true and correct. I further understand and agree that the conditions on the reverse side of the claim form and the conditions in the appropriate Provider Manual apply to this claim.

19. Signature	20. Date

Reset Form

TC-0139 (updated 8/28/19) RDA 656

Figure B.3: Adjustment/Void Request Form